ACTION OF THE SAN DIEGO COUNTY SOCIETY

The San Diego County Medical Society, of which the writer of this article is secretary, fully realizes the principles embodied in this battle, and believes that now is the time to organize and make articulate the entire profession and the taxpaying public in order that the problem may be solved immediately and rightly. To this end the society is throwing its support behind the National Economy League, whose leaders embrace such distinguished figures as Newton D. Baker, Elihu Root, Alfred E. Smith, General John J. Pershing, Rear Admiral Richard Byrd, and Admiral Sims. To do otherwise is to court financial disaster for the country and the erection eventually of a real trust in state medicine, as opposed to the private practitioner and hospital. May I suggest a vigorous course of action by every medical society?[2]

233 A Street.

DOCTORS AND CLINICS

By C. L. MULFINGER, M. D.
Los Angeles

DURING the past two years economic aspects of the practice of medicine have received more attention in public discussion than at any time within the knowledge of the present generation. Various surveys have been undertaken—local, state, national, and even international—with a view of arriving at an accurate estimate of the costs of medical care. In these surveys special attention was paid to the remuneration received by the physician and to the cost of hospitalization and accessory expense to the patient. One thing, however, has been overlooked in these surveys, and that is, the amount of gratuitous services rendered by the medical profession. The briefly published reports of tax-supported institutions are much in evidence in these surveys, but little information is given about the numerous clinics which are privately supported and have staffs of devoted attending physicians who give freely and without public recognition of both their time and service to the care of indigent and near-indigent citizens.

PURPOSE OF THIS PAPER

This article may be regarded as an attempt to show briefly the amount of charity work done by attending physicians in seven of these privately supported clinics in the Los Angeles metropolitan area, especially pointing out the mounting figures of the last three years. For the purpose of making the report on this question reliable, a brief questionnaire was sent out to the ten largest privately conducted clinics in the Los Angeles area. Of these, seven answered the four brief questions which were submitted to them.[1] These questions were:

1. How many patient visits per year have you had in your clinics for the past three years?
2. How many doctor hours per year for the past three years?
3. Has the social status of your patients changed noticeably in the past three years?
4. What is the average charge per patient made?

The answers received were as follows:

I. CLINIC PATIENT VISITS

	1929-30	1930-31	9 months only 1931-32
Clinic No. 1..	51,932	57,166	70,224
Clinic No. 2..	2,399	8,250	8,513
Clinic No. 3..	10,357	12,694	16,453
Clinic No. 4..	34,104	35,964	43,844
Clinic No. 5..	23,225	23,225	23,225
Clinic No. 6..	26,815	28,628	30,898
Clinic No. 7..	71,123	90,946	115,000 estim.
	219,961	256,873	308,157

II. DOCTOR HOURS

	1929-30	1930-31	1931-32
Clinic No. 1..	7,616	7,616	7,616
Clinic No. 2..	No record		
Clinic No. 3..	No record	1,617 (ten mos.)	3,147
Clinic No. 4..	6,097	6,097	6,097
Clinic No. 5..	3,612	3,612	3,612
Clinic No. 6..	2,989	3,910	5,503
Clinic No. 7..	10,812	10,812	15,812 estim.
	31,126	33,664	41,787

These figures show an increase of clinic patient visits of 50 per cent in 1931-1932 over 1929-1930. For this increase in patient visits at the clinic there has been a corresponding increase in the number of doctor hours which amounted to almost 33 per cent.

MONEY VALUE OF THE SERVICES DONATED BY PHYSICIANS

Several years ago the Fee Schedule Committee of the Los Angeles County Medical Association estimated that the doctor's hour should be worth $12 to the patient. This was considered a conservative estimate. Taking this as a basis of calculation, it would follow that, in the seven clinics whose reports were submitted, the physicians rendered $501,447 worth of service to the general public in 1932; and if all the free or part free clinics in this area were included in our report there is no doubt that the sum of the service rendered gratis would mount up to $1,000,000 for the current year.

The lay public knows nothing of this service nor reads a public record of it. If some philanthropist or philanthropic organization were to give

2 The Southern California branch of the National Economy League has just been organized, with headquarters at 548 South Spring Street, Los Angeles. Membership enrollments may be sent to that address or by telephone, Mutual 2289. Membership is without obligation, the organization being supported by voluntary contributions. Its purpose is to fight extravagance in all phases of local, state, and federal government. The matter discussed above is only one of its efforts. Additional facts and figures may be found in the American Medical Association Bulletin of November 1932, pages 199 ff., being abstracts from General Frank T. Hines' address, "The Major Problems of Veteran Relief." See also December, 1932, California and Western Medicine, page 425.

1 A questionnaire survey of some Los Angeles clinics. The clinics whose social departments and directors have furnished the writer with the above facts are: All Nations, White Memorial Hospital Clinic, Santa Rita, Children's Hospital Clinic, Pasadena Hospital Dispensary, Orthopedic Hospital Clinic, and Eye and Ear Hospital Clinic. For their kindness and helpfulness the author wishes to express his gratitude. All these clinics are members of the Los Angeles Community Chest, with the exception of the Pasadena Hospital Dispensary, which is a member of the Pasadena Community Chest.

that much money to public charity, there would be ample display of striking headlines for the eye of the common man for weeks. There should be, therefore, no criticism of the Committee on the Costs of Medical Care when they suggested that physicians should be paid for services rendered to the indigent in each community. Directors of the clinics have made an approximate estimate that the physicians of the attending staff have each given up two weeks of time annually to serve the patients in their clinics.

COMMENT

It is the consensus of opinion among social workers and directors of philanthropic institutions that the social status of the patients seeking medical care in clinics has undergone a marked change within the past two years. One person who is directing an out-patient department in one of the local clinics has recently said: "In 1931-1932 we have noted fewer foreigners in our clinic. In their place we have 75 per cent of American laborers, men of the skilled labor class, such as carpenters, plumbers, auto mechanics, dependents of clerks, actors, musicians, etc." This statement bears out the truth of the experience of the social workers who gave the answer to question three in this report.

In the matter of clinic fees, the average charge is twenty-five cents for the first registration, and ten cents for each following visit. A minimum charge is made for x-rays, for laboratory work and for special dressings to those who can afford to pay. The cost of the average patient per visit to the clinic, where such estimates have been made, is from $1.09 to $1.79, which is considerably cheaper than the cost per patient visit in the out-patient department of tax-supported institutions.

To resume our conclusions once more, an enormous amount of medical and surgical work is being done gratuitously by the attending staffs of the nontax-supported clinics and out-patient departments of the Los Angeles area. Such work has received little or no public recognition in the lay press and was not considered in surveys of the costs of medical care.

It is questionable whether the medical profession will be able, in the face of the present economic trend, to give so full-heartedly as it has in the past of its time and support to these institutions without some form of pecuniary reward.

2014 Seventh Street.

ETIOLOGY OF INGUINAL HERNIAE

By PHILIP STEPHENS, M. D.
Los Angeles

DISCUSSION *by W. W. Roblee, M. D., Riverside; Gunther W. Nagel, M. D., San Francisco; C. Lewis Gaulden, M. D., Los Angeles.*

THE average patient coming into an office today for examination and advice wants to know the reason for his disease or disability, and the average consultant attempts to explain, or to set forth, a reason for the existing condition. In so doing, it appears that he is either careless or neglects to make the proper distinction between cause and effect. Especially is this true in the discussion of herniae with our patients in general and its influence upon the public, lay and legal in particular. There is at present such a marked confusion of ideas regarding the causes of herniae even among the rank and file of our own profession that it is little wonder that legal boards, judges, insurance companies, and compensation commissions have so many opinions and varied rulings, all more or less confusing and conflicting in the interpretation thereof. We are continually being asked by the various interested state and legal bodies for our opinions and should, without hesitation, freely express ourselves. Unfortunately some of us do not, and in view of this fact, I am finding my excuse for briefly reviewing the subject.

COMPARATIVE ANATOMY

It is easy to assume that hernia has always existed in man, and we are told that biologically it is the direct result of his assumption of the erect posture. In all vertebrates, except man, the chief support of the abdominal contents is the upper abdomen, the lower abdominal wall having within it the inguinal rings, so with the added gravitation and the necessary openings, the fact that man (due to his erect posture) is the only sufferer from hernia is easily accounted for. It is said that hernia almost never occurs in the four-footed animals in spite of the fact that many of them have open processus vaginalis peritonae. We are also taught that as a result of our assuming the upright posture, there is quite a difference not only in the arrangement of the abdominal contents, but a marked lengthening of the mesenteric attachment, permitting the descent of the intestine through the inguinal canal. In animals the mesentery is given off at a right angle to the spine or posterior parietes; in man it descends almost parallel thereto.

Inasmuch as approximately 90 per cent of all herniae are inguinal (although the increase of postoperative hernia has somewhat lowered this figure to 82.3 per cent) we will, in a measure, confine our discussion to this particular type, namely, inguinal herniae.

ANATOMY

A brief review of the anatomy of the sac, the canal and the contiguous structures is at this point necessary, along with something of embryologic physiology. The persistence of the patent funicular process in the male and the canal of Nuck in the female provides the potential hernial sac an escape of the viscera downward, into and through the rings. If we accept this congenital or sacular theory (and it is accepted generally) it is interesting to know that in the male the funicular process is larger and longer, and both rings—internal and external—in the entire inguinal canal are much larger, owing to the size, descent, and ultimate destination of the descending testicle in late embryonic life. After birth the increasing size, weight and mobility of the gravitated testes exert